## FORM **BCA 2.10 (MCA)** (rev. July 2021) **ARTICLES OF INCORPORATION**

**Medical Corporation** 

Secretary of State
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-9522
www.ilsos.gov

Remit payment in the form of a cashier's check, certified check, money order or an Illinois attorney's or CPA's check payable to Secretary of State.

Filing Fee: \$150	Franchise Tax S	S Total \$	File #	Approved:				
Sul	bmit in duplicat	e ———— Type or print cl	early in black ink ————	- Do not write above this line				
. Corporate Na	ame:							
	Must end with one	of the following words or abbre	viations: "Chartered," "Limited,"	" "Ltd," "Service Corporation" or "S.C."				
2. Initial Regist	Initial Registered Agent:		Middle Name	Last Name				
Initial Regist	Initial Registered Office:							
3 -	Number		Street	Suite # (P.O. Box alone is unacceptable)				
		City	<b>IL</b> ZIP	County				
	on will be given	rch and knowledge; prov by employees of the cor						
I. Paragraph 1	Paragraph 1: Authorized Shares, Issued Shares and Consideration Received:							
Class		Number of Shares Authorized	Number of Sha Proposed to be I					
				\$				
				TOTAL = \$				

Paragraph 2: The preferences, qualification, limitations, restrictions and special or relative rights in respect of the shares of each class are:

For more space, attach additional sheets of this size.

5.	a.	PTIONAL:  Number of directors constituting the initial board of directors of the Corporation:  Names and addresses of persons who will serve as directors until the first annual meeting of shareholders or until their successors are elected and qualify:									
		Name Addres	ss		City, State, ZIP	,					
6.		PTIONAL: Estimated value of all property to be owned by the Coring year wherever located:	\$								
	b.	Estimated value of the property to be located within thing the following year:	\$								
	C.	Estimated gross amount of business that will be trans- tion during the following year:	\$								
	d.	Estimated gross amount of business that will be tran- business in the State of Illinois during the following ye	from places of	\$							
	Att izir tio	PTIONAL: OTHER PROVISIONS  ach a separate sheet of this size for any other provisions preemptive rights, denying cumulative voting, regular other than perpetual, etc.).									
Ο.	Th	NAME(S) & ADDRESS(ES) OF INCORPORATOR(S)  The undersigned incorporator(s) hereby declare(s), under penalties of perjury, that the statements made in the foregoing Articles of Incorporation are true and correct.									
	Da	ted,,, Year	-								
		Signature and Name			Address						
	1.	Signature	1		Street						
		Name (type or print)		City/Town	State	ZIP					
	2.	Signature	_ 2.		Street						
		Name (type or print)		City/Town	State	ZIP					
	3.	Signature	_ 3.		Street						
		Name (type or print)		City/Town	State	ZIP					
	Sig be the	gnatures must be in BLACK INK on an original document. gnatures must be in BLACK INK on original document. used on conformed copies. NOTE: The incorporator e Medical Practice Act or an Illinois attorney.	cument. Carbon must b	Carbon copy, copy, photocop e either one or	photocopy or rubber s y or rubber stamp signat more persons license	tamp signa ures may only d pursuant to					
Th	ne i	I: Fee Schedule nitial franchise tax is assessed at the rate of 15	Note 2: Return to:								
(N	linin	per \$1,000) on the paid-in capital represented in purn initial franchise tax is \$25.)	Firm name								
ех	emp	e see filing periods set forth below regarding the fotion amount for each year. (Tax amount minus exemp	Attention  Mailing Address								
	a ne	gative number, no franchise tax due.)		_	Mailing Addres	S					
Fr		gative number, no franchise tax due.) hise Tax Liability Exemption Amounts		_	Mailing Addres  City, State, ZIF						

After 1/1/21 Exemption \$1,000.00

• The minimum total due (franchise tax + filing fee) is \$150.